



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

Respondent Name

TARGET CORP

Carrier's Austin Representative Box

Box Number 39

MFDR Tracking Number

M4-05-9727-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated July 14, 2005: "The Carrier did not provide a proper explanation code in this case nor a proper explanation in conjunction with the 'M' payment exception code as required by the TWCC Rules and Commission instructions." "The Carrier is allowed to deduct any personal items and may only deduct non-documented services and items and services, which are not related to the compensable injury. At that time, if the total audited charges for *the entire admission* are below \$40,000, the Carrier may reimburse at a 'per diem' rate for the hospital services. However, if the total audited charges for *the entire admission* are at or above \$40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission'."

Requestor's Supplemental Position Summary Dated October 28, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment...The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least two reasons...The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons..."

Amount in Dispute: \$31,312.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated July 8, 2005: "The Requestor asserts it is entitled to reimbursement in the amount of \$32,430.19, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement...Carrier requests an **Order of Reimbursement** for any payment previously made over the amount calculated under the methods described in the above referenced SOAH decisions..."

Respondent's Supplemental Position Summary Dated August 3, 2005: "Carrier has previously responded to this dispute... Carrier maintains its position as outlined in the original response."

Respondent's Supplemental Position Summary Dated September 12, 2011: "Respondent submits this Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV...Based upon Respondent's initial and all supplemental

responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)..."

Responses Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2004 through July 29, 2004	Inpatient Services	\$31,312.19	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on June 20, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on June 28, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated November 5, 2004
 - SDAY-M-Reimbursed according to the state per diem rates.
 - INCL-M-This procedure is included in the basic allowance of another procedure.
Explanation of Benefits dated December 16, 2004
 - NSUB-F-After carefully reviewing the resubmitted invoice, additional reimbursement is not justified.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 836.0. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that

discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:

- The requestor’s position statement asserts that “...if the total audited charges for *the entire admission* are at or above \$40,000, the Carrier shall reimburse using the ‘Stop-Loss Reimbursement Factor’ (SLRF). The SLRF of 75% is applied to the ‘entire admission’.”
- The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per 28 Texas Administrative Code §134.401(c)(6).
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
- The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that “Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges...” 22 TexReg 6268-6269. Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	<u>3/22/2012</u> Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	<u>3/22/2012</u> Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.